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A STUDY OF NINETY PSYCHOTIC PATIENTS RETURNED FROM TRIAL VISIT AT THE BEDFORD VETERANS FACILITY

1944

A Thesis

Submitted by

Effie Vranos

(A.B., Clark University, 1943)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

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TABLE OF CONTENTS

Chapter — Page

I. INTRODUCTION....1

A. Purpose and Scope....1
B. Method....3

II. THE TRIAL VISIT....7

III. FAMILIAL, SOCIAL AND ECONOMIC BACKGROUND....13

A. Family Background....15
B. Intelligence - Educational and Occupational History....18
C. Social Adjustment....21
D. Military History....23

IV. FROM HOSPITAL TO REHOSPITALIZATION....27

A. Rehospitalization Due to Return of Psychotic Symptoms....31
1. Return Influenced by Family Setting....31
a. Lived with Relatives....32
b. Inharmonious Relationships within the Family....35
c. Emotional Trauma Suffered Because of Family Changes....38
d. Too Long or Inadequate Hospitalization...38
e. Inadequate Supervision at Home....39
f. Environmental Changes Due to Marital Failure....40
2. Alcoholic Concomitant in Return of Symptoms....40
3. Returnees Manifesting Psychosomatic Complaints....42
4. Sex Factors Influencing the Return....43
5. Paranoid Delusions Affecting Rehospitalization....44
6. Returnees Involved in Civil Law Violations..44
7. Return Allegedly Due to Job Discouragement..46
B. Returned by Relatives....47
C. General and Physical Check-up Affecting Return.48
D. Relative Length of Trial Visit....50
E. Employment of Patients on Trial Visit....51

V. SUMMARY AND CONCLUSIONS....53

A. Summary....53
B. Conclusions and Recommendations....60

TABLE OF CONTENTS

Chapter | Page

I. INTRODUCTION 1

A. Purpose and Scope 1
B. Method 3

II. THE TRIAL VISIT 7

III. FAMILIAL, SOCIAL AND ECONOMIC BACKGROUND 15

A. Family Background 15
B. Intelligence - Educational and Occupational History 18
C. Social Adjustment 21
D. Military History 25

IV. FROM HOSPITAL TO REHOSPITALIZATION 27

A. Rehospitalization Due to Return of Psychotic Symptoms 31
B. Return Initiated by Family Setting 31
a. Lived with Relatives 32
b. Inharmonious Relationship within the Family 35
c. Emotional Trauma Suffered because of Family Changes 35
d. Too Long or Inadequate Hospitalization ... 35
e. Inadequate Supervision at Home 35
f. Environmental Changes Due to Marital Failure 40
g. Alcoholic Concomitant in Return of Symptoms 40
C. Returnees Manifesting Psychosomatic Complaints 42
D. Sex Factors Influencing the Return 43
E. Personal Delusions Affecting Rehospitalization 44
F. Returnees Involved in Civil Law Violations .. 44
G. Return Alleged Due to Job Discouragement .. 46
H. Returned by Relatives 47
I. General and Physical Check-up Affecting Return 48
J. Relative Length of Trial Visit 50
K. Employment of Patients on Trial Visit 51

V. SUMMARY AND CONCLUSIONS 53

A. Summary 53
B. Conclusions and Recommendations 60

TABLE OF CONTENTS (Cont.)

APPENDIX.....63

BIBLIOGRAPHY.....65

LIST OF TABLES

Table		Page
I.	Diagnostic Distribution	6
II.	Family Background	16
III.	Work History	20
IV.	Social Adjustment	22
V.	Onset of the Psychosis	24
VI.	Military History	25
VII A.	Reason for Rehospitalization of War I Patients	28
VII B.	Reason for Rehospitalization of War II Patients	29
VIII.	Length of Trial Visit	49
IX.	Employment of Patients on Trial Visit	52

LIST OF TABLES

Table		Page
I.	Diagnostic Distribution	6
II.	Family Background	16
III.	Work History	30
IV.	Social Adjustment	38
V.	Onset of the Psychosis	54
VI.	Military History	58
VII A.	Reason for Hospitalization of War I Patients	58
VII B.	Reason for Hospitalization of War II Patients	59
VIII.	Length of Trial Visit	69
IX.	Employment of Patients on Trial Visit	82

Chapter I: INTRODUCTION

When a patient leaves the hospital to take his place again in his family, in his community, or at work, he carries with him the sum of all his past experiences. His extramural adjustment is not only conditioned by his mental illness, but also by previous patterns of life. Long established habits, inherent personality factors, and the preparation for life which is a continuous process begun from early childhood, are all linked with the success or failure of the trial visit. The immediate cause which precipitates rehospitalization, therefore, can best be conceived when viewed with perspective to the patient's total background.

A. Purpose and Scope

The purpose of this study of patients rehospitalized in 1944 is to gain a better understanding of the causative factors in failures of psychotic patients to make an adequate home adjustment while on trial visit. This might suggest better methods for the prevention of further failures, as well as establish some means for making a more accurate social prognosis in the future follow-up of other cases. In pursuing this study the total personality was taken into account, and such questions were raised as how much part insecurity from childhood played in later adjustment. What had been the patient's previous history of

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adaptation as indicated by his ability to get along with others, to set up satisfying goals, and to maintain steady job employment? How well was he equipped to meet economic competition as measured by formal eduation and specific job training? Did his history reveal any serious personality problems such as alcoholism, sexual conflict, or familial discord? Was the mental breakdown a result of a very traumatic experience, or was it the culmination of a series of trying episodes in the patient's life? During the trial visit period were there definite factors in the environment which lent themselves adversely in hastening a relapse of mental symptoms? In what way could social service have been a greater aid to these patients?

This study is based on the psychiatric records of forty-eight World War I veterans and forty-two World War II veterans, making a total of ninety who came back from a trial visit in 1944 to be rehospitalized at the Veterans Facility in Bedford, Massachusetts. On the original readmission list there appeared one hundred and ten names, but sixteen of these were duplications due to a second trial visit readmission in the same year; four others were eliminated from this study because the readmission was a matter of technical procedure, such as the patient who returned the same day as a result of transportation difficulty. Of the remaining ninety, thirteen returned for treatment of

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physical ailments and according to hospital records, bore no indication of emotional or mental maladjustment. Although one may question whether the inclusion of these thirteen cases contributes further to a study of problems in adjustment, the writer feels justified in presenting all cases returned to the hospital, in order to draw a more comprehensive picture of the returnees. The fact that these patients were able to accept medical treatment from the hospital without suffering any serious emotional disturbance is worthy of note in pointing out the kind of relationship which can be built up between hospital and patient. So often a patient will have such great fear of undergoing another long hospital confinement that he will prefer to seek private medical aid rather than return to the scenes of a mental institution. Under such circumstances where the social worker acts as a liason between the hospital and patient she can quiet many of the patient's fears by discussing with him any misconceptions that he may have regarding medical treatment.

B. Method

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is, conditions under which the psychosis took place, how significant a role military life played, and the psychic determinants of age, diagnosis, and length of hospitalization. (See appendix for schedule.) All factual information was taken from the individual psychiatric clinical records. Correspondence files relative to these patients were also examined in order to get a better understanding of the reactions from relatives, and to help clarify environmental details which were not indicated in the clinical records. Unfortunately as a result of the limited personnel in this department, social service records were lacking in most of these cases. There was no way of judging pre-parole investigations or the kind of follow-up guidance rendered by the social service department. Social histories, too, which were included in the psychiatric clinical records were written mostly by the medical staff and consequently were brief and lacked sufficient detail to present a complete social picture.

Table I shows a diagnostic distribution of the patients used in this study. The two groups of sixty-seven Dementia Praecox cases and seven Manic-Depressive cases make a total of seventy-four, or eighty-two per cent of the patients carrying the diagnosis of a functional psychosis, and leave a mere scattering of eighteen per cent among the other six diagnostic categories. For convenience

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DIAGNOSTIC DISTRIBUTION

Types of Psychosis	War I	War II	Total
Dementia Praecox	31	36	67
Manic-Depressive	7	--	7
General Paresis	5	--	5
Psychopathic Personality	1	3	4
Alcoholic Psychosis	2	--	2
Epilepsy	1	1	2
Post-Traumatic Psychosis	1	1	2
Psychosis w. Mental Deficiency	--	1	1
Total	48	42	90

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Chapter II: THE TRIAL VISIT

The purpose of the hospital in placing the patient on trial visit instead of granting an outright discharge is to extend further guidance and supervision until the patient feels more secure on the outside. A trial visit may be from one month to three months in duration, at the end of which period the patient may have another three months' extension, provided he has been making favorable progress. This quarterly extension is continued until a full year away from the hospital is completed, when the patient is then given a discharge. (There are exceptions to the trial visit plan for those patients whose diagnosis does not warrant close supervision or who have come to the hospital voluntarily, or for observation only.)

The customary procedure in a trial visit is for the medical staff to make this recommendation to the patient's relatives after the patient has been re-examined by them, and the social service department has investigated pertinent aspects of the home environment. It is permissible, however, for the patient's relatives to initiate the request for a trial visit, upon which the medical staff will make a decision. Herein there is much elasticity in the hospital's policy, for the relatives have the right to take the patient home under almost any condition except where the patient may do actual harm to himself or to others. Should

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the medical staff feel strongly convinced that the patient actually will not do harm to anyone but still has a need for further hospitalization, a trial visit may be refused and the patient allowed release only "Against Medical Advice", in which case the patient is prohibited from being re-admitted to the hospital for ninety days. The term "Against Medical Advice" induces many relatives to reconsider their request; nonetheless, there is still a great gap between the trial visit recommended by the medical staff and the trial visit allowed after much discussion on the part of the staff.

During the trial visit period, the hospital offers supervision in the home adjustment of the patient through its social service department. If the environment creates tension for him, efforts are made to ameliorate the external conditions, whether it be by giving interpretation to the relatives or by effecting a situational change. At the same time the social worker may aid the patient to regain confidence in himself, and may discuss problems with him that are threatening his recovery. She may also encourage him to make suitable vocational choices and may refer him to proper resources when more information is needed. In every case the social worker's understanding of the patient will affect the extent and the quality of the service she can render him. She must be able to relate the

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dynamic factors of the patient's past experiences to his present mental diagnosis, and both of these to the trial visit environment , in order that she may set up with the patient some tentative goal in the type of adjustment which he may be able to make in the family, in the community, or at work.

A mental breakdown may be the culminating reaction to a multiplicity of causes, or it may be caused by a weak constitution meeting an insurmountable obstacle. This concept is well described by Dr. Strecker in his analogy of a mental disease to a physical ailment.

> Disease is almost always the culmination of a long series of more or less detrimental and destructive conditions which eventually become sufficiently strong to break down the barriers of natural and acquired resistance. The tremendous importance of even such general considerations as age, race, climate, nutrition, occupation, hygiene, habits of life and the like, cannot be overemphasized, and even though it is often true that such general factors would be powerless to produce morbidity in themselves if the direct mediation of a specific cause were wanting, still it is probably also true that without their predisposing influences, this cause in itself would not exert any harmful effect.
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> It would seem, therefore, that in some sense we are always dealing with total reactions which are the end result of the constant interplay between individual and environment.....(One man's) resistance is either greater or less at one time than at another, and its strength is dependent upon the addition and subtraction of all the upbuilding and deteriorating conditions of his whole life.
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an organically natural to an unnatural or diseased status.[1]

The above quotation indicates that resistance is an all-important factor; and, in this respect, the trial visit is a test of the patient's ability to live adequately in his home and in his community. His resistance to being overcome by adverse conditions of daily living may be predicted in some measure by the degree of recovery from mental symptoms he has attained before he leaves the hospital. Ideally, complete remission from all symptoms would offer him a maximum resistance, for then he would be in full contact with reality in all spheres and could meet new situations more easily. In practice this is not always possible. From the medical point of view not all patients can recover fully or have complete remission of symptoms; and from the medical view, a prolonged hospitalization may be as detrimental as one that is too brief. Then too, there is the pressure from eager but misunderstanding relatives who insist upon taking the patient home. It may be concluded, therefore, that patients leaving the hospital have reached variable degrees of recovery, and that the prognoses based on the illness alone will similarly vary.

On the other hand there are those who, though they may have reached maximum recovery and may have attained a

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complete remission of symptoms, bear a poor prognosis because of unsound habits of long duration, such as chronic alcoholism or psychopathic personality. The repetition of detrimental habits and inability to exercise self-control may then precipitate the return of psychotic symptoms, or cause them to get into trouble in the community.

Of no less importance is the question of what effects external factors will have upon the patient. Is he returning to a marital situation to which he cannot adjust? Is he going back to an over-protective mother or a domineering father? Do his feelings of inferiority gain greater proportion when he is put in competition with those stronger and more able than himself? What constitutes an adequate or an inadequate adjustment?

The connotation of the word "adjustment" takes into account two factors, the personality and the object to which it must adjust, the environment. Since the patient's ability to adjust varies, the magnitude of the environment is enlarged or contracted in proportion to what he can meet adequately. Where one patient may be expected to conform only to his family and neighborhood, another may be expected to make a satisfactory economic adjustment. The older chronic patient, for example, who has regressed considerably may be able to live outside the hospital on a dependency status for a long or a short time according to the manner

in which he is helped or tolerated by other members of the family; while on the other hand a young patient, having fully recovered from a psychotic episode, would be expected to make a vocational and a social adjustment commensurate with his age and intelligence.

In looking forward to understanding the problems of the patient on trial visit, points that should be considered are: (1) That the medical prognosis of the patient varies according to the diagnosis, duration of illness, and the degree of recovery upon leaving the hospital; (2) that environmental conditions influencing the patient are variable in regard to interpersonal relationships, actual living conditions, and magnitude of social contacts; (3) that the patient bears distinct personality features based upon his past experiences which may hinder or help his recovery; (4) that the patient is constitutionally endowed with certain strengths and weaknesses which are in turn influenced by environment in creating a given amount of resistance; and (5) that resistance fluctuates from time to time according to the internal and external forces influencing the personality.

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Chapter III: FAMILIAL, SOCIAL, AND ECONOMIC BACKGROUND

To completely understand the patient who leaves the hospital to make an adjustment on the outside, one must have an understanding of his personality based upon a longitudinal study of the entire history and setting. It is not enough merely to know the diagnosis and the immediate conditions of the environment.

> The most clear-cut evaluation in the study of mental disorder has been the recognition of the continuity of mental life in relationship not only to the organic growth of the individual, but to the experiences which he undergoes and survives. A mental disorder is to be studied as a stage to stage process. Very rarely do we find mental disorders developing from a clear sky.[1]

In infancy and early childhood the personality is first primarily narcissistic: the child is concerned only with its own somatic and psychological needs. He displays passive, intaking trends in relation not only to food and drink but also to love and attention. As he gets older and more secure, and after he has had sufficient gratification, this narcissism is altered gradually until he is able to spill over his excess energy, love and attention to others, his parents, his siblings, and an ever widening circle of personal contacts. He will become more altruistic, less selfish and less self-centered in relative proportion to the amount of satisfaction he received in his

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> The degree to which he can love and give to others depends on his own inner security, based on having had enough for himself. If his security is precarious, love of others depletes him and he feels humility and inferiority.[2]

The security of a child may be weakened by the death or the desertion of one or both parents, or by adverse parental attitudes such as rejection or favoritism toward a sibling. Similarly, personality traits in the parents such as marked dominance, emotional instability, or extreme passivity may inhibit the child from normal self-expression. He will repress conflicts which may later find an outlet as neurotic symptoms. Even more hazardous and frightening to the child is the bizarre or absurd behavior of the alcoholic parent, or the unexpected reactions of a family member who is mentally ill.

As the child grows older and identifies with the community, the status which his family has there will further add to or detract from his sense of security. With these primary attitudes and self-evaluation he enters into the school relationship, later into his occupation, and finally into community and nationwide endeavors. His home has provided him with his first tools, good or bad, to face the world of reality. If later he makes poor identification, has repeated failures, or develops a defeatist attitude,

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A. Family Background

Table II shows the family background of the ninety returnees divided into three categories: normal homes, broken homes, and those with emotional instability. By "normal homes" is meant those homes in which the patient was brought up by both parents, and there were no known traits of alcoholism or mental and emotional disturbances in other family members. Under "broken homes" were grouped those in which the patient was reared by only one parent, by one parent and a step-parent, by relatives, or in an orphanage. Homes with "emotional instability" were classified as those in which personality defects on the part of one or both parents or the siblings, such as alcoholism, mental illness, neurotic traits, or extreme dominance, may have caused a feeling of insecurity, fear, or confusion in the child, the patient, growing up in that environment. In those cases where a broken home and emotional instability in other members of the family occurred simultaneously, the family was listed under the broken home group.

Table II shows that only thirty patients, or one-third of the group, came from homes that were reported normal. Thirty-two came from homes considered emotionally unstable, and twenty-one from broken homes, making a total

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Table II

FAMILY BACKGROUND

Type of Home	Types of Psychosis *							Total No.	Per Cent
	FC	CP	AL	GP	EP	PT	MD		
Normal Home	22	--	--	4	1	2	1	30	33
Broken Home	16	2	1	1	1	--	--	21	23
Emotionally Unstable	29	2	1	--	--	--	--	32	36
No Data	7	--	--	--	--	--	--	7	8
Total	74	4	2	5	2	2	1	90	100

*Abbreviations: FC - Functional
CP - Psychopathic
AL - Alcoholic
GP - Paresis
EP - Epileptic
PT - Post-Traumatic
MD - Mental Deficiency

Table II

FAMILY BACKGROUND

Type of Home	Types of Psychosis *						Total	Per Cent
	FC	CP	AL	CF	HP	PT	MD	No.	
Normal Home	22	--	--	4	1	2	1	30	33
Broken Home	16	2	1	1	1	--	--	21	23
Emotionally Unstable	29	2	1	--	--	--	--	32	36
No Data	7	--	--	--	--	--	--	7	8
Total	74	4	2	5	2	2	1	90	100

*Abbreviations: FC - Functional
CP - Psychopathic
AL - Alcoholic
CF - Paresis
HP - Epileptic
PT - Post-Traumatic
MD - Mental Deficiency

of fifty-three, or fifty-nine percent, who did not grow up in a normal home environment. In seven cases there was not sufficient data upon which to draw conclusions. Of the thirty-two who came from homes which were emotionally unsound, eight had fathers characterized as "nervous", extremely domineering, or grouchy and irritable; four had mothers described as highly emotional or "nervous"; two patients were very attached to their extremely over-protective mothers. In nine families there was a history of a mental breakdown on the part of a parent. Five cases showed that there were personality defects on the part of siblings: two patients had siblings with a mental disorder; one had an epileptic sibling; and in the two other cases the siblings were described as high-strung and neurotic. Of the broken home group, nine grew up with only one parent, three with a father and six with a mother. Four were reared by relatives, one in an orphanage, and seven in a home with a step-parent.

In reference to their diagnoses, forty-five patients with a functional psychosis came from psychologically inadequate homes as compared with twenty-two from normal homes. The four patients with psychopathic personalities and the two alcoholics were equally divided between broken homes and those emotionally unstable. Of the two epileptics, one came from a normal home and the other from a broken home.

The backgrounds of the two post-traumatic cases and the one with mental deficiency were reported normal.

B. Intelligence - Educational and Occupational History

> (Intelligence) is biologically conditioned; educationally and culturally developed and analyzed; and to the extent that the organism is potentially capable and habitually stimulable, it is expressed typically in every self-directed action.[3]

It is known that intelligence plays a great part in personal adjustment to daily living, to ways in which one solves problems, makes decisions, and sets up goals. Emotions or organic changes, however, may lower mental output. Emotions may inhibit energy or reduce motivation and stimulation and thereby lower the effort or persistence level. Since this study deals with individuals who probably always suffered from emotional difficulties, one may infer that they may have possessed more ability than was shown by ways in which our culture judges intelligence, that is, by educational and vocational achievement. Progress on their part may have been inhibited by emotional blocking rather than by a lack of intellectual ability.

Education, nonetheless, is a preparation for life, and formal education is here considered in its relation to preparing the individual for job opportunities. On the grammar school level it is customary to equip the individual

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with the fundamentals of the three "R's", and it is not until high school or a vocational school that any occupational training is offered. Of the World War I veterans, eight attended high school and three graduated. Five others graduated from college. Of the World War II veterans, twenty-two attended high school and eleven graduated. Two others attended business college. Scholastically then, only eight from the first group and thirteen from the second group received sufficient training for a particular type of job. All sixty-nine of the others had to learn a trade as apprentice workers or advance by work experience if they wished to make any occupational progress or attain some degree of job security. Otherwise they would have had to accept the common jobs that fall to the unskilled, menial labor, monotonous factory work, and odd jobs.

Table III was divided into five job classifications: the unskilled, which included laborers, truck drivers, factory workers, and odd job workers; the semi-skilled, which included apprentice masons, apprentice machinists, shoe stitchers, and rubber cutters; the skilled, which listed carpenters, shoemakers, and machinists; business managers, which included a grocery store and a restaurant; and professional, which grouped a high school teacher, a college instructor, and one foreign representative of the Department of Commerce. These jobs were further described

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Table III

WORK HISTORY

Occupation	No.	Satisf.	Unsatisf.	No Data
Unskilled	69	32	25	12
Semi-Skilled	7	4	2	1
Skilled	9	6	2	1
Business Manager	2	--	1	1
Professional	3	3	--	--
Total	90	45	30	15

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Business Manager	2	--	1	1
Professional	3	3	--	--
Total	90	45	30	15

as satisfactory and unsatisfactory. By "satisfactory" is meant that the patient was employed fairly steadily and that changes were made for valid reasons. By "unsatisfactory" is meant sporadic work periods, much loafing, and short term employment. Sixty-nine of the patients were employed as unskilled workers and of these, thirty-two made satisfactory work adjustments, as compared to twenty-five who did not do well; twelve from this group lacked descriptive details regarding occupational adjustment. There were seven semi-skilled and nine skilled workers, two business managers, and three professional workers. Although the groups are too small to show any definite trends, one would expect that job changes and dissatisfactions would decrease in proportion to the degree in which one is vocationally trained to make his own choice.

C. Social Adjustment

The pre-schizoid personality is commonly considered to be introverted and self-conscious and to have few friends. Emotionally this type of person does not yield easily to others, either because he feels inferior or because he is essentially narcissistic and does not easily form identifications. Sixty-seven of these patients were diagnosed as dementia praecox; therefore it is natural that several of the traits listed in Table IV would be characteristic of them. Fifty-one were described as seclusive, as contrasted

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Table IV

SOCIAL ADJUSTMENT

Type of Adjustment	No. of Cases	Total
Personality Traits:		
Seclusive	51	
Good Mixer	20	
Over-Aggressive	5	
No Data	14	90
Sexual Adjustment:		
Heterosexual	42	
Autistic	18	
Homosexual	9	
No Data	21	90
Marital Status:		
Single	68	
Married	16	
Divorced	3	
Separated	2	
Widowed	1	90

Table IV

SOCIAL ADJUSTMENT

Type of Adjustment	No. of Cases	Total
Personality Traits:		
Secluative	31	
Good Mixer	30	
Over-Aggressive	5	
No Data	14	90
Sexual Adjustment:		
Heterosexual	42	
Autistic	18	
Homosexual	9	
No Data	21	90
Marital Status:		
Single	60	
Married	16	
Divorced	3	
Separated	5	
Widowed	1	90

to only twenty who were good social mixers. Forty-two indicated heterosexual interests. There was no data on twenty-one cases, and twenty-seven had reached an arrested stage in their psychosexual development, being on an infantile or homosexual level. Sixty-eight were single; sixteen were married, of whom only one was a War II veteran; three were divorced, two being War II veterans; and two were separated from their wives and one widowed, all War I veterans.

D. Military History

In the military setting it has been found that "the earliest and most flagrant breakdowns are among men whose personalities were previously unstable and who had not effected a satisfactory life adjustment." [4] Table V indicates that thirty-three, or seventy-nine per cent of the War II veterans broke down in domestic service with no combat experience, as contrasted to seven in foreign service. Of the War I veterans, forty-one broke down in civilian life and had experienced no combat service, and only three broke down in foreign service.

Table VI shows that the duration of military service for the War II veterans ranged all the way from a few months to three years, making the average duration 17.5 months. However it must be pointed out that these patients became

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* Grinker and Spiegel, op. cit., p. 14.

Table V

ONSET OF THE PSYCHOSIS

Place	War I No.	War II No.
In Civilian Life	41	2
In Domestic Service	4	33
In Foreign Service	3	7
Total	48	42

Table VI

MILITARY HISTORY

No. Months in Service	War II Veterans				
	No. of Men	R A N K *			
		Pvt.	Corp.	Sgt.	Officer
0 - 6	5	4	1	--	--
6 - 12 (1 year)	13	12	1	--	--
13 - 18	11	11	--	--	--
19 - 24 (2 years)	7	6	--	1	--
25 - 30	3	2	--	1	--
31 - 36 (3 years)	3	3	--	--	--
Total of War II Men	42	38	2	2	0
Ranks of War I Men	48	34	7	5	2
Total Number	90	72	9	7	2

* Naval equivalents in rank included under army; e.g., pvt. or S3/c, etc.

Table VI

MILITARY HISTORY

No. Months in Service	War II Veterans			
	No. of Men	RANK*		
		Pvt.	Corp.	Sgt.	Officer
0 - 6	5	4	1	--	--
6 - 12 (1 year)	13	12	1	--	--
13 - 18	11	11	--	--	--
19 - 24 (2 years)	7	6	--	1	--
25 - 30	3	2	--	1	--
31 - 36 (3 years)	3	3	--	--	--
Total of War II Men	42	38	2	2	0
Ranks of War I Men	48	34	7	5	2
Total Number	90	72	9	7	2

* Naval equivalents in rank included under army; e.g., Pvt. or SS\c, etc.

mentally ill before the actual military discharge, and periods of service ranging from several weeks to months may have been spent in army hospitals. Table VI also shows the relatively few rank promotions among these men, with only two officers out of the War I veterans, none for War II, and a total of seventy-two out of ninety, or eighty per cent, who remained in the lowest rank.

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Chapter IV: FROM HOSPITAL TO REHOSPITALIZATION

It is possible that during his hospital confinement the patient had phantasied the home environment idealistically, dwelling only upon the pleasurable memories. Once at home, therefore, he may suffer some emotional disturbance by virtue of disappointment that his reality experience does not measure up to the product of his imagination. Furthermore, old conflicts may be revived on his return to the situations where they originated. Then there is also the possibility of meeting a change in the environment for which he is not emotionally prepared, such as the presence of a new in-law, or absence by death of a former family member.

This chapter will of necessity have a negative approach for the purpose here is to find where in the present environment of the trial visit there may have been elements that affected the patient adversely. Were the inter-personal relationships of the home such that the patient felt unwanted or inferior? Did he feel inadequate to make a marital adjustment? Did certain aspects of his personality such as paranoia, alcoholic tendency, or sexual conflict prove to be the greatest obstacles? Did the community fail by not offering work to those who sought it?

On the other hand, there is a group of patients who were returned by relatives for rehospitalization even though their mental and physical condition remained essentially

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Table VII A

REASON FOR REHOSPITALIZATION OF WAR I PATIENTS

Reason	Diagnosis							Sub-Tot.	Total
	FC	GP	AL	CP	EP	PT	MD*		
Relapse									28
Manifested in:									
Home Environment	9	--	--	--	--	--	--	9	
Alcoholism	5	--	2	1	--	--	--	8	
Psycho-asthenia	6	--	--	--	--	--	--	6	
Sexual Offences	--	--	--	--	--	--	--	--	
Paranoid Ideas	4	--	--	--	--	--	--	4	
Law Violations	--	--	--	--	--	--	--	--	
Job Failure	1	--	--	--	--	--	--	1	
Returned by Relatives	10	--	--	--	--	1	--		11
Physical Check-up	3	5	--	--	1	--	--		9
Total	38	5	2	1	1	1	0		48

*Abbreviations: FC - Functional GP - General Paresis
AL - Alcoholic Psychosis
CP - Psychopathic Personality
EP - Epilepsy PT - Post-Traumatic Psychosis
MD - Psychosis with Mental Deficiency

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REASON FOR REHOSPITALIZATION OF WAR I PATIENTS

Reason	Diagnosis							Sub-Tot.	Total
	FC	GP	AL	CP	EP	PT	MD*		
Relapse									28
Manifested in:									
Home Environment	9	--	--	--	--	--	--	9	
Alcoholism	8	--	3	1	--	--	--	8	
Psycho-asthenia	6	--	--	--	--	--	--	6	
Sexual Offenses	--	--	--	--	--	--	--	--	
Paranoid Ideas	4	--	--	--	--	--	--	4	
Law Violations	--	--	--	--	--	--	--	--	
Job Failure	1	--	--	--	--	--	--	1	
Returned by Relatives	10	--	--	--	--	1	--	11	
Physical Check-up	3	3	--	--	1	--	--	9	
Total	38	3	3	1	1	1	0	48	

*Abbreviations: FC - Functional GP - General Paresis
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MD - Psychosis with Mental Deficiency

Table VII B

REASON FOR REHOSPITALIZATION OF WAR II PATIENTS

Reason	Diagnosis							Sub. Tot.	Total
	FC	GP	AL	CP	EP	PT	MD*		
Relapse									38
Manifested in:									
Home Environment	18	--	--	1	1	1	--	21	
Alcoholism	6	--	--	1	--	--	--	7	
Psycho-asthenia	1	--	--	--	--	--	--	1	
Sexual Offences	4	--	--	1	--	--	--	5	
Paranoid Ideas	1	--	--	--	--	--	--	1	
Law Violations	2	--	--	--	--	--	--	2	
Job Failure	1	--	--	--	--	--	--	1	
Returned by Relatives	--	--	--	--	--	--	--		0
Physical Check-up	3	--	--	--	--	--	1		4
Total	36	0	0	3	1	1	1		42

*Abbreviations: See Table VII A

Table VII B

REASON FOR RESOSPITALIZATION OF MAR II PATIENTS

Reason	Diagnosis							Sub. Tot.	Total
	PC	GP	AL	CF	EP	PT	MD*		
Relapse									38
Manifested In:									
Home Environment	18	--	--	1	1	1	--	21	
Alcoholism	6	--	--	1	--	--	--	7	
Psycho-madness	1	--	--	--	--	--	--	1	
Sexual Offences	4	--	--	1	--	--	--	5	
Paranoid Ideas	1	--	--	--	--	--	--	1	
Law Violations	2	--	--	--	--	--	--	2	
Job Failure	1	--	--	--	--	--	--	1	
Returned by Relatives	--	--	--	--	--	--	--	0	
Physical Check-up	3	--	--	--	--	--	1	4	
Total	36	0	0	3	1	1	1		42

*Abbreviations: See Table VII A

unchanged. Here one may question if these relatives fully comprehended what was entailed in the care of a mental patient. Did they find that the patient had changed more than they had anticipated, and that his care over a long period had become tiresome? Did the relative who requested the trial visit fail to consider what the effect would be on the other family members and thus did not foresee the friction that followed?

In a third category are those patients who returned to the hospital in order that they might receive medical treatment for physical ailments, but who had presented no serious emotional or mental problems other than those they had had upon originally leaving the hospital.

Table VII shows a division of the returnees into three major groups: (a) those patients rehospitalized due to a return of psychotic symptoms manifested in one form or another; (b) those whose mental and physical condition remained essentially unchanged but who were returned by relatives: and (c) those who voluntarily came back for physical treatment. The first group was further divided into smaller categories for study purposes. In some cases the writer questioned whether the patient felt insecure because he was not well integrated within the family circle; in other instances, insecurity and frustration may have been felt by the patient as a result of family discord or sibling

rivalry. These patients were all listed as having been influenced in their psychotic relapse by factors in the home environment. Alcoholism as a detrimental concomitant in a return of psychotic symptoms was similarly separated as affecting another group of patients. Psycho-asthenia, sexual offences, paranoid ideas, law violations, and job failure were the means by which many of the other patients exhibited their mental symptoms, and for purposes of emphasis and further delineation these too were listed in individual categories. In so dividing the patients, it is unavoidable that there will be a considerable over-lapping of causative factors for relapse of symptoms. However, as previously stated, these divisions were made to illustrate certain features of environment, personality, and past habits, and not to prove conclusively that any one factor was the sole determinant in bringing about the patient's rehospitalization.

A. Rehospitalization Due to Return of Psychotic Symptoms

1. Return Influenced by Family Setting

Thirty patients, or exactly one-third of the entire group of returnees, presented factors in the home environment which may have contributed to the psychotic relapse. Nine of these patients were World War I veterans, and twenty-one were War II veterans. The duration of trial visit for these patients ranged from less than one month

to nine months. Twenty-seven carried the diagnosis of a functional psychosis; the other three of post-traumatic psychosis, psychosis with epilepsy, and psychopathic personality. All of the World War II veterans had been hospitalized for less than one year; seven of the War I veterans had been hospitalized over ten years, one for seven years, and another for five years.

The home environment of these patients will be discussed from the point of view of (a) those having to adjust to living with relatives outside the family unit, (b) those having to adapt themselves to inharmonious relationships within the family, (c) those who suffered emotional trauma due to unexpected changes in the family, (d) those who could not adapt themselves to the family setting because their hospitalization had been either too long or too brief, (e) those who did not receive sufficient supervision at home, and (f) those who had to return to their parents' home or to live with relatives because of the failure of their marriage.

a. Lived with Relatives

Seven patients went to live in the homes of married siblings, and here one must question how each patient fitted into the family unit, for once a person has married, his siblings become a part of the out-group. The newly-formed unit and subsequent offspring make up the family

unit or the in-group. Under such circumstances the patient may not feel accepted into a satisfying family life. To go still further, there may be controlled or overt hostility on the part of thein-law, who may regard the patient as an intruder. Except for two cases, there was no recorded evidence as to how the in-laws reacted to the patients. In one case the brother-in-law, who frankly admitted his annoyance toward the patient, felt that the patient took too much of his wife's time, had to be supervised like a child, and was constantly in the way, thus interfering with his privacy. In the other case the patient attempted to kill his sister and brother-in-law, but aside from this fact no reference to possible motive was mentioned in the hospital records, and the patient was rehospitalized in a psychotic state.

Four of this group of patients were War I veterans, and certain aspects of their personalities must be taken into consideration. All four of them had been hospitalized at various times for a period exceeding ten years and represent more or less the chronic patients. Their egos had undergone considerable regression and they presented a picture of marked dependency. As they lacked the initiative and drive to go out and compete in the labor market the active role they could accept was apt to be that of doing household chores and small errands. This not only

meant that they would be around the house constantly, but that they also would require careful supervision.

On the other hand the War II veteran may be spurred on to greater activity commensurate with his age, but he presents a different problem. It is natural in the second decade of life to have strong sexual drives. The presence of an attractive sister-in-law in the home or a brother-in-law of his own approximate age might arouse in the younger patient an awareness of his own sexual needs. Social inhibition, a typical characteristic of most of these patients, would keep him from seeking active social contacts, and he would dwell on his secret thoughts with increasing guilt feelings. Associated with these, there might be a tendency towards conversions, substitutions and regressions to other erotic activities, which in turn might add still further to his guilt and result in anxiety.

Whether frustration on the part of the patient who lived with a married sibling was due to his feeling of being unwanted or because of sexual conflict cannot be proven from recorded material, but these factors are worthy of some consideration.

Two patients, a War I veteran and a War II veteran, spent their trial visits at the homes of aunts, one step removed from the sibling consanguinity as related to in or out-group feeling. An aunt may take a maternal interest

in the patient and make him more accepted than he would be in a circle of competitive interests, but in-law interference and cousin rivalry may alter any such ideal situation. The War I veteran remained on trial visit for five months but very little was mentioned in his record as to the type of adjustment which he made. The War II veteran remained on trial visit less than one month, and his aunt made it obvious to hospital authorities that she did not consider the patient as having a desirable influence upon her children. She remarked that the patient was a source of annoyance to her and the children and did not "fit" into the family.

b. Inharmonious Relationships within the Family

Three of the War II veterans went to live in homes where one of the parents was a step-parent. The proverbial "wicked step-father or step-mother" may have had some meaning for these patients even if limited to the sense that their own parent had to be shared by some outsider. There may have been a revival of the psychological concept of the Oedipus complex with a strong desire to possess the mother alone, a feeling of marked hostility toward the step-father, and where there were half-siblings, an intensification of the rivalry situation.

One of the patients went to live with his mother and elderly step-father. The step-father remained idle all day

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One of the patients went to live with his mother and elderly step-father. The step-father remained idle all day

while the mother took care of a large rooming-house which she owned; nothing was recorded as to how the patient occupied himself. He remained on trial visit for seven months. The second patient went to live with his mother, step-father, two half-brothers and five half-sisters. This family had always experienced financial difficulties; the home was crowded and the sleeping accommodations poor. Very similar to that of the second patient was the plight of the third patient who shared his home with his father, step-mother, two brothers, four sisters, and two half-brothers. Here too economic stress had always played an important role in the family, and furthermore the father was described as brutal and domineering. Both of these patients remained on trial visit less than one month.

Personality traits of other members of the family are particularly significant to patients who are mentally ill, and in the case of three patients there were marked personality problems on the part of the parents. The fathers of these patients were described in such terms as "nervous", domineering, dogmatic, irritable, and miserly. In one case the mother, also, was referred to as emotionally unstable. All three of these patients were War II veterans. Two remained on trial visit for one month, and the other remained three months.

In one instance the patient went home to a "house

divided" between the sister and the father who did not get along well together but showed common interest in the patient. Whether they were able to control their personal differences for the sake of the patient or whether they were a source of irritation, again can only be questioned. This patient remained on trial visit for nine months, one of the longest home visits experienced by any of the War II returnees.

Quite paradoxical to the other cases in this group of problems in the home environment are three cases that were selected because standards in the homes were so high that the writer felt that the patients may have been troubled by feelings of inadequacy and inferiority. Two of these patients came from large families with over four siblings each, and the other had two siblings. In all three cases both parents and siblings were reported as healthy and very well adjusted. One may question if the exuberant surroundings of well-being and robust health of the other members of the family made these patients more conscious of their own shortcomings and the possible disgrace they might have caused the family. Two of the patients showed hostility towards their families during their relapse; one wanted to travel and get away from home and the other acquired a threatening attitude toward his family. On the third case there was not sufficient infor-

mation to record details. Two patients remained on trial visit for three months and one remained for only one month.

c. Emotional Trauma Suffered Because of Family Changes

Psychotic symptoms on the part of one patient were precipitated as a result of the father's death while the patient was at home on trial visit. Another patient was granted a trial visit in custody of his father, but when he reached home could not get accustomed to the fact that his father and mother had separated. He brooded about it and became depressed.

d. Too Long or Inadequate Hospitalization

Failure as a result of a premature trial visit was illustrated by two of the returnees. In one case the parents of the patient felt that their summer camp would benefit him, and took him home against medical advice that he was not free from symptoms. A few days later the patient was returned because of his bizarre behavior. A slightly different picture was presented by another patient who similarly was not mentally much improved at the time he left the hospital yet remained on trial visit for nine months. During his trial visit he lived with his family on a farm and at no time, his family reported, did he make any progress or show a good adjustment.

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ized so long that they had become inured to institutional life and could not adjust on the outside. This was demonstrated by two patients who felt restless at home, missed fellow patients, and wanted to return to the hospital. Both these patients were World War I veterans, and their trial visits lasted four and five months respectively.

e. Inadequate Supervision at Home

Two War II veterans who might have made a better adjustment had they received better supervision from their parents had been diagnosed as a psychopathic personality and as an epileptic with mental deficiency. The patient with the psychopathic personality presented a repetition of the usual pattern of his type, refusal to take orders, instability, and lack of moral consciousness. His history revealed that his father was an actor and playwright and the family had moved a great deal; and the writer gained the impression that the home atmosphere had always carried an element of insecurity. When the patient was returned to the hospital his parents reported that they had been unable to control him. Though there is often little hope offered for the psychopathic personality, parental stability and adequate supervision might have had some controlling influence.

The epileptic patient suffered seizures as a result of neglecting his medication and was consequently rehospital-

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The epileptic patient suffered seizures as a result of neglecting his medication and was consequently rehospitali-

ized. The fact that he was also mentally deficient further indicated that the responsibility should have rested with the parents.

f. Environmental Changes Due to Marital Failure

Patients whose home adjustment may have been influenced by the memory of a marital failure are two War II veterans and one War I veteran. The War I veteran went to live with a cousin because his wife informed him that she was no longer interested in him. Two two younger patients had lived a short marital life of less than one year's duration prior to their army enlistment, and both were divorced at the time of their entrance into the hospital. Upon their release both patients returned to their parental home. The hospital records did not indicate in any way how these patients felt about their former mates, or how much the loss meant to them. Such information would have been pertinent in a follow-up study and guidance program for these patients, in the event that they would have needed help in attaining new interests. The War II returnees remained on trial visit from one to two months, and the War I returnee, who got along very well with his cousin, returned to the hospital after nine months.

2. Alcoholic Concomitant in Return of Symptoms

Table VII shows eight War I veterans and seven War II veterans whose rehospitalization was influenced by alcohol-

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3. Alcoholic Concomitant in Nature of Symptoms

Table VII shows eight War I veterans and seven War II veterans whose temporal situation was influenced by alcohol-

ism. The diagnoses of these patients included eleven dementia praecox cases, one manic-depressive, two alcoholic psychoses, and two psychopathic personalities. From their history of alcoholic habits previous to their psychoses, eleven were reported as heavy drinkers, three as moderate, and on one no information was available. Further study of their histories showed that during their developmental period twelve of these patients had lived in broken or emotionally unstable homes. Thereby one may trace the thread of insecurity as having started in early life. Some of the underlying motives for alcoholism are explained by two authors in the following quotations:

> The alcohol has helped to postpone any sort of solution of mental conflict. It has been looked upon as an aid and in many patients affords a false sense of security and temporary escape from unpleasant tensions.[1]

> When we analyze the alcoholized mind, we see in alcoholic phantasies a tremendous amount of imaginative ego-compensating material that is burnt up in these phantasies and never reaches reality. Since the pictures evoked by alcoholic phantasy are so soothing and satisfying, so flattering to the lacerated ego, and so void of effort, the incentive to create an enjoyable state of mind based on reality ceases to exist, and we have the phenomenon of a search for dissatisfaction or boredom in the environment in order to justify the return of the alcoholic state of mind.[2]

Facts revealed by the social histories of these

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1 James Hardin Wall, "A Study of Alcoholism in Men", The American Journal of Psychiatry, 16:1393, May, 1936.

2 Edward A. Strecker and Francis T. Chambers, Alcohol: One Man's Meat, p. 46.

patients indicate that alcoholism as an escape mechanism had been a long established pattern in the majority of these cases, and that this indulgence while on trial visit had been a repetition of the old habits. It is also true that the alcoholism may have been symptomatic of a return of mental illness in which the patient felt the onset of a depression, or became hyperactive in a manic phase and over-indulged in everything. At any rate it may be concluded that patients who are alcoholically inclined will need more supervision, and if possible, special professional guidance.

3. Returnees Manifesting Psychosomatic Complaints

It is an accepted fact that various types of somatic complaints have their genesis in psychic conflicts. Therefore the following group properly fits under the heading of "Relapse" shown on Tables VII A and VII B. Under the classification of Psycho-asthenia there is one War II veteran, age 31, and six War I veterans, the youngest of whom is forty-four years old. Four of these patients had had histories of neurasthenia and hypochondriasis prior to their psychotic episodes, and one developed somatic delusions as part of his psychosis. The other two did not show any significant data pertinent to previous complaints, but on return from trial visit both complained of vague head and body pains. Of this group five were married and two were single. Five of these patients were chronic hospital cases and the

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other two had been hospitalized less than one year. The duration of their trial visits ranged from one to six months, and all of the patients carried the diagnosis of a functional psychosis.

One may question if some of these somatic complaints may not have been the result of failure of make an adequate sexual adjustment. Evidence of such a case was presented by one of the patients, whose somatic complaints followed a sexual experience through which he imagined that he had become impotent. A psychosis or any serious emotional disorder may affect the libido, and the consequent difficulty of adjusting to marital life may cause some of these patients undue alarm and anxiety, thus making it easy to revert to their old somatic pains as an excuse for their inadequacy.

4. Sex Factors Influencing the Return

The five patients included in those where sex factors influenced rehospitalization were all War II, unmarried patients, four of whom carried the diagnosis of Dementia Praecox and one, Psychopathic Personality. The psychopath returned for hospitalization because of his sexual promiscuity and his subsequent fears of having contracted a venereal disease, which caused him considerable anxiety. Two patients became very depressed due to strong conflicts over homosexual tendencies. Another became hyperactive and attempted a sexual assault on a girl in his neighborhood,

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and the fifth one exposed himself in front of his sisters. The last two cases seemed to demonstrate symptoms of a psychotic relapse, whereas in the first three cases sexual conflict appeared to have been the causative factor in bringing about other symptoms. These patients were all grouped together, however, because the rehospitalization was precipitated by these sexual aberrations.

5. Paranoid Delusions Affecting Rehospitalization

Five patients, all of whom carried the diagnosis of Dementia Praecox, paranoid type, were rehospitalized because of their paranoid delusions. Four of these were World War I veterans with a history of mental illness exceeding ten years. Two of the patients were especially paranoid toward strangers and fellow employees; one wrote threatening letters to a former army nurse, one had many paranoid ideas concerning his wife, and another towards his family.

6. Returnees Involved in Civil Law Violations

Two of the returnees expressed their psychotic symptoms in a manner affecting the community, and were sent to the hospital by court referral. One was charged with petty larceny and the other with breaking and entering. A brief glance at the underlying factors shows some points of interest.

The first patient, age 19, came from an extremely religious family. Four of his aunts were Ursaline nuns and

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the maternal uncle was a missionary; his mother, likewise, was extremely religious. Some attempt to break away from this pious atmosphere seems to have been indicated in the record by a history of periodic drinking bouts since the age of seventeen. His occupation previous to enlistment had been that of a grave digger. There had been no previous court record. While on trial visit he became restless, wanted to travel, and was referred for rehospitalization by the court, which charged him with petty larceny.

The second patient, age 20, had gone to live with his grandmother following the second marriage of his mother in his early childhood. He was very fond of her and returned to her home during his trial visit. The social history of this patient revealed one previous court charge for breaking and entering for which he had been given a suspended sentence. His school history, work record, and personal habits had all been exemplary, which may indicate that his one court experience might have been the result of some wild escapade about which he could later have developed some guilt feelings. This patient was returned from trial visit by court referral after having broken into a tailor shop to get his suit of clothes instead of waiting until the shop opened the following day.

Both of these patients were obviously psychotic upon their return to the hospital, but there seems to be some

relation in their behavior to their past; the first manifesting behavior against the principles of a good Christian, and the second repeating an earlier act which may have caused him some anxiety.

7. Return Allegedly Due to Job Discouragement

The two patients put in this category explained the symptoms of depression which led to their rehospitalization as due to inability to find work. Both did attempt to work, but their failures were reflective of other psychic maladjustment. In regard to jobs alone, these patients should have had no difficulty in finding work at a time when the war created a great labor demand. Some consideration should be given to this factor in view of the likelihood of handling patients in future years who can adequately meet a job requirement, but who actually may become discouraged because there are none available.

More reasonable underlying factors for the failures of these two patients were (1) the inadequate recovery of the War I veteran, who eloped and was granted trial visit status at the request of his sister in spite of medical advice that he needed further care; and (2) the lack of immediate relatives of the other patient, who lived alone in a rooming house, receiving only occasional and not too adequate supervision from distant relatives. His loneliness and lack of incentive may have been a truer cause for his failure.

B. Returned by Relatives

Of the eleven patients who were returned by relatives ten were chronic cases and carried the diagnosis of a functional psychosis, and one had been hospitalized for three years and diagnosed as a post-traumatic psychosis. This group, for the most part, represents dependent, regressed individuals whose return to the hospital was not caused by any psychotic fluctuation, but because their dependency drained the energy of other members of the family, so that they were finally surrendered to institutional care. Oftentimes these patients are taken out periodically to spend "vacations at home" of several months' duration. The seasonal pattern of "vacation time" could be followed on four of these by the concurrent dates of trial visit from year to year, the length of which varied from two to five months. Likewise four of the other patients were taken by relatives who understood the limitations of their illness but wanted to be helpful in providing the patient with a "change", which lasted from one to two months. One patient remained out one month but wanted to return to the hospital because he missed the companionship of other patients. The remaining two patients were returned by their wives, who found them "difficult" to have at home. In both the latter cases there seem to have been marital conflicts, with one of the patients having a strong homosexual attachment and the other

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feeling "mismated". In this group, too, one may note some deviations in regard to causative factors for rehospitalization, but all these patients were put in this category because the nature of their illness remained essentially unchanged up to the time of their return to the hospital.

C. General and Physical Check-up Affecting Return

Thirteen patients voluntarily returned for rehospitalization in order that they might receive care and treatment of physical ailments, and according to hospital records bore no indication of any new emotional or mental complications. Nine of these patients were World War I veterans and the remainder War II. Six were diagnosed with functional psychoses, five with general paresis, one with epilepsy, and one with psychosis with mental deficiency. It is interesting to note that of the entire group of ninety returnees there were only five with general paresis, and that all five of these returned merely for a medical check-up which required only a few days' rehospitalization. The specific causes for the return of the thirteen cases in the group ranged all the way from a few days' general check-up and subsequent discharge, to dental work, sprains, and sinus trouble.

As mentioned earlier, the fact that patients were able to return for physical treatment without suffering emotional trauma is indicative of the kind of understanding

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Table VIII

LENGTH OF TRIAL VISIT *

Duration	War I No.	War II No.	Total No.	Per Cent
One-third Year	27	29	56	73
Two-thirds Year	9	6	15	19
Over two-thirds Year	3	3	6	8
Total	39	38	77	100

* Patients who returned for physical treatment were not included.

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and relationship which can be built up between a mental institution and a patient. The fact that a patient is on trial visit does not make him immune to physical ailments, and he should have sufficient faith and confidence in the hospital so as not to fear that he will jeopardize his freedom or chances for another trial visit by accepting medical services offered by the hospital. To some patients the memory of the mental agony suffered during their hospitalization is apt to arouse in them a certain distrust of the hospital. In the trial visit follow-up, therefore, the social worker should be sensitive to the physical needs of the patient also, and help him to overcome any emotional blocking which may interfere with his seeking the proper assistance.

D. Relative Length of Trial Visit

Table VIII does not show any significant difference between the War I group and the War II group, but rather it does show strong general trends. In this table there are an almost equal number in both groups, and one may note the high correlation between the two in the duration of their trial visits. It is indicated that most of the returnees, seventy-three per cent, were rehospitalized within the first third of the year, that nineteen per cent came back in the second third of the year, and that only eight per cent of the returnees remained out over two-thirds of a

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D. Relative Length of Trial Visit

year. One may predict, therefore, that the longer these patients remain on the outside, the less likely they are to be rehospitalized in a given year. The most difficult period of their adjustment is that of the first third of the year, and consequently more intensive follow-up guidance by the social worker is required during this period.

E. Employment of Patients on Trial Visit

As indicated by Table IX, a total of fifty-four patients, or sixty per cent, remained idle during the period of their trial visit, seventeen found steady employment, and fourteen changed jobs frequently. The work record of the younger patients was slightly better than that of the older ones, but again, the similarities between the two groups are more outstanding than the differences. The fact that seventy-three per cent were rehospitalized within the first third of the year would indicate that perhaps they had not been out long enough to seek employment. On the other hand, one may wonder if some organized rehabilitation program continued after hospitalization might not have been helpful in preparing more of these patients to find a vocational placement, taking into account, of course, the range in abilities and interests that one would expect to find in any group of this size.

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Table IX

EMPLOYMENT OF PATIENTS ON TRIAL VISIT

How Employed	War I No.	War II No.	Total No.	Per Cent
No Employment	30	24	54	60
Regular Employment	10	7	17	19
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No Data	3	2	5	6
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Chapter V: SUMMARY AND CONCLUSIONS

In this study an attempt was made to gain a better understanding of the causative factors in the rehospitalization of psychotic patients who had been granted a trial visit from the Bedford Veterans Facility in 1944. The patients studied were veterans of World War I and World War II, numbering forty-eight and forty-two respectively, making a total of ninety. The majority of these patients, eighty-two per cent, were diagnosed as having a functional psychosis, and the other eighteen per cent were divided among six other diagnostic categories: general paresis, psychopathic personality, alcoholic psychosis, epilepsy, post-traumatic psychosis, and psychosis with mental deficiency.

Due to the limited personnel in the social service department, the patients' hospital records lacked adequate social data which would have been of great value in the follow-up care of patients. In the great majority of cases records of pre-parole investigations and social service follow-up care were lacking. Similarly, since the social histories were written for the most part by a busy medical staff, they did not have sufficient detail to present a complete social picture. The writer, therefore, based her conclusions on the psychiatric clinical records in which

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were included those social histories taken by the psychiatrists. Correspondence files relative to the patient were also used whenever they offered pertinent information.

The personality of the patient was studied as a whole in order to gain an understanding of the various aspects of family background, school life, inter-personal relationships, occupational experience, and military life which contributed toward the strengths and weaknesses of the mature person.

The composite picture of the personalities presented in this study revealed that fifty-nine per cent of the patients had not had the proper start in life from their family background, as indicated by thirty-six per cent who grew up in emotionally unstable homes and twenty-three per cent who came from broken homes.

When the school progress made by these patients was considered it was assumed that the grammar school trained the individual in the fundamentals of the three "R's" and that the program for vocational preparation was left to the secondary or vocational schools. Data on scholastic achievement showed that of the War I group only eight patients had completed a secondary school, as compared to thirteen from the War II group who had done the same. Theoretically then, twenty-one patients had received job preparation, in contrast to sixty-nine who had had to

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accept jobs for the untrained, or train by apprenticeship.

By coincidence the work records of the patients indicated that sixty-nine had been employed as unskilled workers, although these did not all coincide with those who had not finished high school. The remaining twenty-one patients had worked at jobs which had ranged from the semi-skilled to the professional in gradually decreasing numbers. In connection with job satisfaction it was pointed out that satisfaction was apt to increase in proportion to the extent to which one was equipped to make his own occupational choice.

Success in work, in play, or in the family relationship is often dependent upon the extent to which a person can identify with others or adapt himself to group situations. Social traits of the patients studied revealed that the majority, fifty-one in number, had always been seclusive and had experienced difficulty in relating to other people.

This inability to relate easily to others, or to work in groups, partially may have been the cause for the relatively few promotions in rank received by these patients during their military experience. Their records showed that eighty per cent started their military service in the lowest rank and received no promotions. The average length of military service for the War II veterans was 17.5 months

although this figure does not mean active service, for periods ranging from several weeks to months may have been spent in army hospitals pending a medical discharge.

In the total picture of these patients prior to their psychotic episode one may note the general weaknesses and drawbacks in their personalities, starting from the insecurity of their home life during their childhood, and augmented by their poor training to meet economic competition, their difficulty in getting along with others, and finally, their failure in military life. Their mental breakdown had been a final blow and this, together with the pattern of failure experienced all along their lives, may well have robbed most of them of their self-confidence. Where so many setbacks had been experienced by these people everything possible should have been done by the social service department to make the environment of the trial visit favorable to their recovery and to give them encouragement.

The trial visit was a test of each patient's ability to withstand the obstacles and frustrations of daily living, and in this respect the past experiences of the patient, together with the condition of his mental diagnosis, determined the strength of his personality. On the other hand environmental factors during the trial visit, such as inter-personal relationships, occupational satisfaction, and living conditions contributed in presenting favorable

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mined the strength of his personality. On the other hand
environmental factors during the trial visit, such as
inter-personal relationships, occupational satisfaction,
and living conditions contributed in presenting favorable

or unfavorable factors in the patient's opportunity to recover. The type of adjustment made by each patient on trial visit, then, was the outcome of the interplay between his personality and his environment.

As to the precipitating factors which caused their rehospitalization, the ninety patients in this study were divided into three major groups: (1) those patients who were rehospitalized because of a return of psychotic symptoms manifested in one form or another; (2) those whose mental and physical condition remained essentially unchanged but who were returned by relatives; and (3) those who voluntarily came back for treatment of physical ailments and general check-up, and who showed no indication of mental or emotional complications. In the second group, those patients returned by relatives, the limitations of the patient were well understood by most of the relatives who had asked to take the patients on a temporary basis, and no setback was suffered by them as a result of the trial visit.

The third group, thirteen patients who returned for physical treatment, is accredited to the good relationship between hospital and patient, which allowed them to return with confidence.

In the first group, those who were rehospitalized because of a relapse of psychotic symptoms, there were

sixty-six returnees. In thirty cases it was felt by the writer that the environment of the trial visit had presented factors which might have had adverse effects upon the patient. Nine patients went to live with relatives and the question was raised as to whether these patients had been properly accepted and integrated into a satisfying family life. The problem of inharmonious family relationships was raised in the home situations found in ten other cases. Three patients went to live in homes where there was a step-parent and in two instances there were also half-siblings; three patients went to live in homes where one or both parents presented personality problems; one patient went home to live in an environment of open friction between his sister and his father; and three other patients went to homes whose standards were so high that they may have become frustrated by feelings of inadequacy and inferiority. Two patients experienced emotional trauma during the trial visit because of family changes, one due to the death of his father, and the other because of the marital separation of his parents. In three cases the patients went to the homes of parents or relatives after having experienced marital life prior to their army enlistment and subsequent hospitalization. The parents of two other patients did not exercise proper control in regulating the habits of the patients while they were under supervision.

Two patients were unable to make an adequate home adjustment as their trial visit had been premature because they had not recovered sufficiently; and two found difficulty at home because they had become so inured to institutional life that they became restless while staying away from the hospital.

In other patients who suffered a psychotic relapse some reflection of their backgrounds and previous habits was seen in the manner in which they manifested their psychotic symptoms: Fifteen patients, eleven of whom had had previous records of heavy drinking, had an alcoholic concomitant in their psychotic relapse; seven patients, five of whom had had a previous history of hypochondriasis, returned because of psychosomatic complaints; five patients whose paranoid trends gained greater proportions were rehospitalized when their attitudes became more threatening; five patients exhibited sexual aberrations; two patients came in conflict with the law, one because he rebelled against the principles of his religious family, and the other because the memory of an old court experience became reactivated.

Seventy-three per cent of the returnees were rehospitalized within the first third of the year; nineteen per cent came back in the second third of the year; and only eight per cent remained out over two-thirds of the year.

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During the trial visit period sixty per cent of the patients remained idle. The younger patients showed a slightly better employment record than the older, but there was no appreciable difference between the two groups.

The study leads to the following conclusions and recommendations:

1. That social histories should be written by trained psychiatric social workers so that a complete picture of the patient's personality may be presented. This information would not only be of value to the psychiatrist in forming a diagnosis, but it would also help the worker to give better guidance to the patient during his trial visit period.

2. A pre-parole investigation should be made by the social service department for every patient going on trial visit, and records of such findings should be filed. In the pre-parole investigation full consideration should be given regarding the personalities of all of the family members in the home environment, and not just those who have asked to have the patient at home.

3. Careful interpretation of the patient's limitations, conflicts, and weaknesses should be given by the social worker to the relatives who are to take the patient home.

4. The social worker should see the patient before he leaves the hospital in order that a good rapport may be

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4. The social worker should see the patient before he leaves the hospital in order that a good report may be

established for future contacts.

5. It was shown by this study that most of the failures in adjustment occurred within the first third of the year. Therefore social service guidance in follow-up care should be more intensive during the first part of the year, with a gradual decline in the amount of supervision as the year goes on.

6. It was pointed out that factors in the home may reactivate old conflicts on the part of the patient, or cause him other emotional disturbances. Where there is any doubt regarding the home environment an intermediate step should be provided between hospital and home care. Such an intermediate step might even prove beneficial to all patients in giving them greater assurance and poise before returning home.

7. Sixty per cent of the patients remained idle during the period of their trial visit, which fact is evidence of the need of some rehabilitation program to keep these patients mentally stimulated and divert them from the danger of morbid self-introspection.

In compiling this study very few details were presented concerning the exact nature of the patient's illness and degree of recovery upon leaving the hospital. These factors were omitted because they are within the realm of the psychiatrist and not that of the social worker. How-

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ever it should be pointed out that because these factors were omitted the pre-psychotic life of the patient and the environmental factors may not have been fairly weighed in determining the failures experienced by the patients who were rehospitalized.

Approved,

Richard K. Conant

Dean

Approved,

Dean

SCHEDULE

Name

Age

Length of service: (Dates) Overseas service?

Length of hospitalization: (Dates)

Date of trial visit: Return from trial visit:

Number of previous trial visits:

Diagnosis: Onset of psychosis:

Significant Family History:

1. Neurotic, psychotic, epileptic or alcoholic determinants in:
   Father
   Mother
   Siblings
   Others

2. Desertion by father: by mother:

3. Death of father: of mother:

4. Patient lived with stepmother: with stepfather:
   with other relatives: foster home: orphanage:

5. Other pertinent facts:

6. Occupation of father:

Early Development:

Normal: Enuresis: Nail biting: Deterred development in talking: in walking:

Illnesses:

Previous Personality:

Seclusive: Aggressive: Good mixer: Shy toward opposite sex:

SCHEDULE

Name

Age

Length of service: (Dates) Overseas service?

Length of hospitalization: (Dates)

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5. Other pertinent facts:

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Early Development:

Normal: Enuresis: Nail biting: Deferred development in talking: in walking:

Illnesses:

Previous Personality:

Sociable: Aggressive: Good mixer: Shy toward opposite sex:

Habits of Alcohol or Drugs:

Excessive: Temperate: Abstinent:

Education:

Occupational History:

Kind:
Steady: Changeable: Lagger: No experience:

Court Record:

Previous Hospitalization for Mental Illness:

Marital Status:

Sex Adjustment:

Heterosexual: Homosexual: Autistic: No data:

Trial Visit Environment: Medical Prognosis of Patient:

Social:
Economic:
Attitude of relatives:

Type of Activity by Patient While on Trial Visit:

No activity:
Home chores:
Irregular outside employment: Kind:
Regular employment: Kind:
No data:

Reason for Rehospitalization:

Present Status:

Habits of Alcohol or Drugs:

Excessive: Temperate: Abstinent:

Education:

Occupational History:

Kind:

Steady: Changeable: Longer: No experience:

Court Record:

Previous Hospitalization for Mental Illness:

Marital Status:

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